STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175525	A. BUILDING _____ B. WING _____	05/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK LANE NURSING HOME	210 E PARK LANE SCOTT CITY, KS 67871

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey. The 2567 was electronically sent on 05/30/23.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without	F 550		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175525	A. BUILDING _____ B. WING _____	05/15/2023

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F 550	Continued From page 1	F 550		

interference, coercion, discrimination, or reprisal from the facility.

§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 46 residents. The sample included 12 residents. Based on observation, record review and interview the facility failed to provide a dignified dining experience for Resident (R) 8, placing the resident at risk for impaired wellbeing.

Findings included:

- On 05/09/23 at 12:20PM, dining observation revealed R8 sat in a wheelchair at an assisted dining table. Further observation revealed Nurse Aide P stood behind the resident, picked up the resident's spoon, and gave R8 a bite of food. Nurse Aide P then walked away from the table.

On 05/09/23 at 12:25PM, Nurse Aide M stood beside R8, picked up R8's fork, and gave her a bite of food. Nurse Aide M then walked away from the table.

On 05/09/23 at 12:35PM, Nurse Aide O sat on a chair beside R8, picked up a spoon, and gave R8 a bite of food. Nurse Aide O then stood up and walked away from the table. Further observation revealed Nurse Aide O came back to the dining table, stood by R8, picked up a spoon, and gave her a bite of food.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175525	A. BUILDING _____ B. WING _____	05/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK LANE NURSING HOME	210 E PARK LANE SCOTT CITY, KS 67871

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F 550	Continued From page 2 On 05/15/23 at 09:00AM, Administrative Nurse D verified the expectation when assisting residents to eat in the dining room was the staff were to sit beside the resident when assisting with the meal. The facility's "Dignity Policy", dated 2/2021, stated each resident will be cared for in a manner that enhances his or her sense of well-being and provide a dignified experience. The facility failed to promote dignity for R8, placing her at risk for an undignified experience and impaired wellbeing.	F 550		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: The facility had a census of 46 residents. The sample included 12 residents. Based on observation, record review, and interview, the facility failed to provide interventions for lack of bowel movements for one Resident (R) 36, who had a history of constipation (difficulty in emptying the bowels). This placed the resident at risk for impaction (the condition of being or process of becoming impacted, especially of feces in the intestine).	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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PARK LANE NURSING HOME	210 E PARK LANE SCOTT CITY, KS 67871

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F 684	Continued From page 3	F 684		

Findings included:

- The Electronic Medical Record (EMR) documented R36 had diagnoses of constipation, diabetes mellitus type 2 (the body's ability to produce or respond to the hormone insulin is impaired), dementia without behavioral disturbance (a progressive mental disorder characterized by failing memory and confusion), weakness, and hemiplegia (paralysis of one side of the body)/hemiparesis (muscular weakness of one side of the body) affecting the non-dominant side.

R36's "Quarterly Minimum Data Set" (MDS), dated 03/03/23, documented R36 had intact cognition and required supervision of one staff for bed mobility, transfers, ambulation, and toileting. The assessment further documented R36 was occasionally incontinent of bowel.

R36's "Clinical Admission Evaluation, dated 11/10/22, documented R36 was alert and oriented, and was continent of bowel.

The "Care Plan," dated 05/05/23, documented R36 used antidepressant (a class of medications used to treat mood disorders and relieve symptoms of depression) medication and directed staff to monitor, document, and report adverse reactions such as constipation, and fecal impaction.

The "Physician Order," dated 12/03/22, directed staff to administer Milk of Magnesia (a laxative), 30 milliliters (ml), by mouth, on the fourth day of no bowel movement, in the evening . The order further directed, if no results in the evening,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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PARK LANE NURSING HOME	210 E PARK LANE SCOTT CITY, KS 67871

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F 684	Continued From page 4	F 684		

continue to step three, Dulcolax (laxative) suppository, in the morning.

The "Physician Order," dated 03/28/23, directed Colace (stool softener), 100 milligram (mg), by mouth, daily, for constipation.

The "Bowel Monitoring Record," dated February 2023, revealed R36 did not have a bowel movement for the following days:
02/03/23-02/06/23 (4 consecutive days)

R36's "Medication Administration Record, (MAR) and clinical record for" February 2023, lacked evidence the staff provided interventions or bowel assessments during the lack of bowel elimination on the above dates.

The "Bowel Monitoring Record," dated April 2023 and May 2023, revealed R36 did not have a bowel movement for the following days:
04/29/23 - 05/02/23 (4 consecutive days)

R36's MAR and clinical record dated April 2023 through 05/02/3, lacked documentation the staff provided interventions or bowel assessments during the lack of bowel elimination on the above dates.

The "Nurse's Notes," dated 05/03/23 at 01:32 PM, documented R36's abdomen protruded, and was hard. R36 complained of pain of ten on a zero to 10 scale (zero representing no pain and 10 the worst pain imaginable). The note further documented the right side of R36's abdomen bulged; he had a small loosely formed bowel movement. R36 reported his abdomen was painful upon palpation;bowel sounds were active in all four quadrants. The resident's heart rate

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175525	A. BUILDING _____ B. WING _____	05/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK LANE NURSING HOME	210 E PARK LANE SCOTT CITY, KS 67871

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F 684	Continued From page 5	F 684		

was slightly elevated and the physician was notified and R36 went to the emergency room.

The "X-ray Report," dated 05/03/23, documented R36's bowel gas pattern was normal and had no evidence of a bowel obstruction (digested material is prevented from passing normally through the bowel);there was mild constipation.

The "Physician Order," dated 05/03/23, directed staff to start the constipation protocol.

On 05/09/23 at 03:32 PM, observation revealed R36 sat in his recliner with his eyes closed.

On 05/10/23 at 10:35 AM, Certified Nurse Aide (CNA) M stated, R36 had no safety awareness and often got up on his own, including toileting himself. CNA M further stated, when a resident had a bowel movement, they document in the kiosk.

On 05/15/23 at 08:00 AM, Licensed Nurse (LN) H stated, there was usually a list that had resident names that had not had a bowel movement for three days and the dayshift nurse would start the bowel protocol of Milk of Magnesium.

On 05/15/23 at 08:10 AM, Administrative Nurse D stated if a resident did not have a bowel movement for three days, staff were to follow the facility's bowel protocol.

The facility's "Bowel Regimen" policy, dated May 2021, documented the policy promoted resident comfort by recognizing bowel needs through routine monitoring. A licensed nurse would assess and review bowel history and implement bowel protocols as needed. The night shift

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 684	Continued From page 6 nursing staff was responsible for initiating a bowel report to identify any residents who had not had a bowel movement in the last 3 days and reporting this information on the 24-hour log, shift report sheet, and implement standing orders. The facility failed to identify periods lacking bowel movement and implement the physician ordered interventions for R36. who had a history of constipation, placing the resident at risk for impaction and decline.	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: The facility had a census of 46 residents. The sample included 12 residents, with one reviewed for pressure ulcers (localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction). Based on observation, record review, and interview, the facility failed to prevent the development of one	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 686	Continued From page 7	F 686		

facility acquired pressure ulcer for Resident (R) 38, who acquired a Stage 2 pressure ulcer (shallow with a reddish base and have a break in the top two layers of skin). The facility failed to implement interventions which included nutritional consults to promote optimal healing and prevent worsening of skin breakdown for R38. This placed the resident at risk for further breakdown.

Findings included:

- The Electronic Medical Record (EMR) for R38 documented diagnoses of hypertension (high blood pressure), anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), vitamin deficiency (a condition of a long-term lack of a vitamin), edema (swelling resulting from an excessive accumulation of fluid in the body tissues), intervertebral disc degeneration (breakdown of one or more of the discs that separate the bones of the spine causing pain in the back or neck), and weakness.

R38's " Significant Change Minimum Data Set" (MDS), dated 12/13/22, documented R38 had moderately impaired cognition and required extensive assistance of two staff for bed mobility, transfers, toileting and extensive assistance of one staff for personal hygiene. The assessment further documented R38 was at risk for pressure ulcers, had no skin issues, no turning or repositioning program, and no pressure relieving devices for her bed or chair.

The "Quarterly MDS," dated 02/24/23, documented R38 had moderately impaired cognition and required extensive assistance of two staff for bed mobility, transfers, toileting, and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 686	Continued From page 8	F 686		

extensive assistance of one staff for personal hygiene. The assessment further documented R38 was at risk for pressure ulcers, had one unhealed Stage 2 pressure ulcer, had pressure relieving devices for her bed and chair, and received pressure ulcer care.

The "Braden Scale Assessment," dated 12/13/22, documented a score of 14, indicating a moderate risk for pressure ulcer development.

The "Care Plan," revised 03/02/23, originally dated 10/26/22, documented R38 had a pressure ulcer to her sacrum (large triangular bone between the two hip bones) related to limited mobility, poor nutritional intake, elimination incontinence, and directed staff to place a pressure reducing cushion in her wheelchair. An intervention, dated 06/27/22 directed staff to follow policies and protocols for the prevention of pressure ulcers, and monitor and document any changes in skin status. An intervention, dated 03/10/23, directed staff to follow Registered Dietician recommendations for wound healing.

The "Physician Order," dated 08/08/22, directed staff to administer a multivitamin with minerals, three tablets at bedtime, for advanced energy support.

The "Skin and Wound Evaluation," dated 12/15/22, documented R38 had an in house acquired Stage 2 pressure ulcer which the area measured 0.2 centimeters squared (cm) x 0.5 cm in length x 0.4 cm width.

The "Physician Order," dated 12/17/22, directed staff to cleanse the gluteal cleft (the groove between the buttocks that runs just below the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175525	A. BUILDING _____ B. WING _____	05/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK LANE NURSING HOME	210 E PARK LANE SCOTT CITY, KS 67871

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F 686	Continued From page 9	F 686		

sacrum to the perineum) region with normal saline, pat dry, and apply a foam dressing to the open area, every 72 hours, and resolve the dressing when healed.

The "Physician Order," dated 12/22/22, directed staff to administer Zinc (a mineral to assist with healing damaged tissues), 50 milligrams (mg), one daily for 14 days, supplement.

The "Skin and Wound Evaluation," dated 01/17/23, documented R38 had an in house acquired Stage 2 pressure ulcer which the area measured 0.6 cm 2 x 1.0 cm x 0.9 cm, light exudate (a mass of cells ad fluid that has seeped out of blood vessels or an organ, especially in inflammation), and had no odor.

The "Physician Order," dated 01/19/23, directed staff to cleanse the open area with normal saline, pat dry, apply Medihoney (medical grade honey that prevents bacteria from building in the wound), to the wound bed, cover with a foam dressing, and resume dressing changes every 72 hours and as needed, every day shift until healed.

The "Skin and Wound Evaluation," dated 02/19/23, documented R38's wound measured 0.5 cm 2 x 0.7 cm x 0.9 cm x 0.4 cm. The evaluation documented the wound was 50 percent (%) slough (dead tissue), 50% granulation (new tissue), light exudate, and no odor.

The "Physician Order," dated 02/20/23, directed staff to cleanse the open area with normal saline, pat dry, apply Cavilon barrier (helps to protect intact or damaged skin from irritation caused by urine or fecal incontinence) to periwound (the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175525	A. BUILDING _____ B. WING _____	05/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK LANE NURSING HOME	210 E PARK LANE SCOTT CITY, KS 67871

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 10	F 686		

area of skin extending beyond the wound edges), let dry, and apply a small amount of hydrogel (used to increase the speed and success of wound healing) to wound bed only, cover with a dry dressing, twice a day and as needed, until healed.

The "Nutrition Note," dated 02/20/23 at 03:39 PM which was over two months after first identification of the Stage 2 pressure ulcer, documented R38 was assessed due to the presence of a Stage 2 pressure wound to the sacrum. R38 was on a multivitamin-mineral tablet daily, on a regular diet, received ensure supplement daily, and her daily meal intake was 51 to 75%. The note directed staff to continue with the vitamin daily, add a nutritional supplement as ordered, and documented the additional supplementation would not be helpful in the healing of the Stage 2 ulcer if nutritional intake does not decline and weight loss does not occur.

The "Wound and Skin Evaluation," dated 05/08/23, documented a Stage 2 pressure ulcer which measured 0.9 cm 2 x 1.6 cm x 0.8 cm x 0.1 cm, 60% slough, 40% granulation tissue, no exudate, and no odor.

The "Physician Order," dated 05/11/23, directed staff to cleanse the open area to sacrum with normal saline, pat dry, apply Cavilon barrier to peri- wound, let dry and apply a thin layer of hydrogel to the wound bed, and cover with a Duoderm (flexible, water proof dressing to reduce infection) dressing, change every 3 days and as needed until resolved.

On 05/11/23 at 09:39 AM, Licensed Nurse (LN) I

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175525	A. BUILDING _____ B. WING _____	05/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK LANE NURSING HOME	210 E PARK LANE SCOTT CITY, KS 67871

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F 686	Continued From page 11	F 686		

sanitized her hands, and donned gloves. R38 laid on her right side while LN I removed the old dressing, changed gloves, cleansed around the per-wound with normal saline. LN I then changed gloves, applied Cavilon barrier around the peri-wound, applied a thin layer of hydrogel to the wound, and placed a Duoderm dressing over the wound.

On 05/10/23 at 10:54 AM, Certified Nurse Aide (CNA) M stated R38 had been on the other hall when she acquired the pressure area; staff encouraged her to allow them to reposition her every two hours.

On 05/11/23 at 10:23 AM, LN G stated she had originally told staff not to disturb R38 at night but after R38 acquired the pressure ulcer, she told staff to encourage R38 to reposition and to change her incontinence brief. LN G further stated that there was a change in staffing, and she was now in charge of wounds and confirmed the Registered Dietician was not involved for a couple of months. LN G stated the consulting firm audited the chart and recommended the dietician be involved, and verified it was the facility policy to notify the physician and dietician when there was skin breakdown.

On 05/15/23 at 08:24 AM, Administrative Nurse D stated the dietician should have been involved with the resident's care when she acquired the pressure ulcer but there had been a change in staffing at the time R38 acquired the wound.

the facility's "Pressure Ulcer/Skin Breakdown" policy, dated April 2018, documented the nursing staff and practitioner would assess and document an individual's significant risk factors for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK LANE NURSING HOME	210 E PARK LANE SCOTT CITY, KS 67871

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 12 developing pressure ulcers, and a Braden scale assessment would be completed upon admission, readmission, quarterly, and upon identification of a pressure ulcer. The policy further documented the physician would order wound treatments and although poor nutritional status was associated with increased risk for pressure ulcer development, no specific nutritional interventions clearly prevent or heal pressure ulcers. Any nutritional supplementation should be based on realistic appraisal of an individual's current nutritional status. The facility failed to implement interventions which included nutritional consults to promote optimal healing, for R38, who acquired a Stage 2 pressure ulcer. This placed the resident at risk for further breakdown.	F 686		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: The facility had a census of 46 residents. The sample included 12 residents, with 10 reviewed for falls. Based on observation, record review, ad interview, the facility failed to provide a safe environment and failed to follow the care plan for two sampled residents, Resident (R) 36 and R38. This placed the resident's at risk for further falls	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175525	A. BUILDING _____ B. WING _____	05/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK LANE NURSING HOME	210 E PARK LANE SCOTT CITY, KS 67871

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 13	F 689		

and injury.

Findings included:

- The Electronic Medical Record (EMR) documented R36 had diagnoses of, diabetes mellitus type 2 (the body's ability to produce or respond to the hormone insulin is impaired), dementia without behavioral disturbance (a progressive mental disorder characterized by failing memory and confusion), weakness, and hemiplegia (paralysis of one side of the body)/hemiparesis (muscular weakness of one side of the body) affecting the non-dominant side.

R36's "Quarterly Minimum Data Set" (MDS), dated 03/03/23, documented R36 had intact cognition and required supervision of one staff for bed mobility, transfers, ambulation, and toileting. The MDS further documented R36 had unsteady balance, no functional impairment, and had two or more non injury falls.

The "Morse Fall Scale," dated 04/28/23 and 05/09/23 documented the resident a high fall risk.

The "Fall Care Plan," dated 05/05/23, documented R36 was a high risk for falls related to gait, balance, and unaware of safety needs. The care plan directed staff to identify toileting trends for staff assistance or supervision for safety, anticipate and meet his needs, be sure his call light was within reach and respond promptly, remind resident to rise slowly, use the call light for assistance, and consult social service about replacing house shoes. The care plan directed staff R36 utilized a motion alarm in his room, and to review information on past falls and attempt to determine cause of falls.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175525	A. BUILDING _____ B. WING _____	05/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK LANE NURSING HOME	210 E PARK LANE SCOTT CITY, KS 67871

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 14	F 689		

The "Fall Investigation," dated 04/28/23 at 07:00 PM, documented staff responded to R36's motion alarm and found R36 on the floor by the end of the bed. The investigation further documented R36 stated he tried to go to bed, and wanted it pushed against the wall as staff had previously moved the bed away from the wall to make it and had not returned it to the proper position. The investigation documented R36 did not have any injuries and verbal education was given to staff.

The "Fall Investigation," dated 05/09/23 at 09:25 PM, documented staff went to R36's room to answer his call light and found him on the floor. The investigation further documented R36 stated he tried to shut his light off since staff had left on. R36 did not have any injury, staff directed R36 to call for assistance and educated staff on increasing safety checks.

On 05/10/23 at 10:35 AM, observation revealed Certified Nurse Aide (CNA) M and CNA O stood on each side of R36, who had his walker in front of him. The CNAs, did not have a gait belt on the resident, per his request, and stood and pivoted R36 from his bed into his recliner.

On 05/10/23 at 10:35 AM, CNA M stated R36 was impulsive and very unaware of safety concerns. CNA M further stated he would get up on his own without calling for staff assistance and would often fall.

On 05/15/23 at 08:00 AM, Licensed Nurse (LN) H stated R36 was a high fall risk as he was impulsive a does not remember to call for assistance so there was a motion alarm in his room.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175525	A. BUILDING _____ B. WING _____	05/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK LANE NURSING HOME	210 E PARK LANE SCOTT CITY, KS 67871

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F 689	Continued From page 15	F 689		

On 05/15/23 at 08:10 AM, Administrative Nurse D stated staff were educated after both falls and should have made sure the bed was back into place as well as the light turned off for the resident.

The facility "Fall Prevention, Documentation, and Reporting" policy, dated January 2013, documented staff identify residents at risk for falls, initiate interventions to prevent falls, reducing the risk of injury due to falls. The staff shall assess all residents for fall risk upon admission and have fall precautions implemented as appropriate, when a resident fall occurs after admission to the facility a root cause analysis shall be initiated ad an incident and accident report be completed. All trends are reported monthly to quality assurance/performance improvement committee.

The facility failed to ensure a safe environment for R36. This placed the resident at risk for further falls and injury.

- The Electronic Medical Record (EMR) for R38 documented diagnoses of hypertension (high blood pressure), anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), vitamin deficiency (a condition of a long-term lack of a vitamin), edema (swelling resulting from an excessive accumulation of fluid in the body tissues), intervertebral disc degeneration (breakdown of one or more of the discs that separate the bones of the spine causing pain in the back or neck), and weakness.

The "Quarterly Minimum Data Set" (MDS), dated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175525	A. BUILDING _____ B. WING _____	05/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 16	F 689		

02/24/23, documented R38 had moderately impaired cognition and required extensive assistance of two staff for bed mobility, transfers, toileting, and extensive assistance of one staff for personal hygiene. The MDS further documented R38 had unsteady balance, upper functional impairment both sides, lower functional impairment on one side, had one non injury and one injury fall since prior assessment.

The "Morse Fall Scale," dated 09/11/22, 09/27/22, 12/13/22, and 02/22/23, documented the resident was a high risk for falls.

The "Fall Care Plan," dated 03/02/23, documented R38 required two staff assistance with transfers and ambulation for short distances, be sure R38's call light was within reach, anticipate and meet her needs, and consult therapy. R38's care plan directed a chair alarm to be utilized while in wheelchair or recliner, a motion alarm to be utilized only while in bed, and to use a fall mat next to the bed when resident lying in bed; educate the resident/family/caregivers about safety reminders and what to do if a fall occurs.

The "Fall Investigation," dated 09/27/22 at 03:42 PM, documented R38 got up to follow staff out of her room; a different staff member intervened to provide R38 stand by assistance, and as she did this, another resident came into the hall without their walker. The investigation further documented the staff member left R38 to assist the other resident and R38 attempted to step backwards, lost her balance, and fell. The resident received a skin tear to her right elbow and a quarter size bump to the back of her head. The investigation documented R38 was taken to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175525	A. BUILDING _____ B. WING _____	05/15/2023

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PARK LANE NURSING HOME	210 E PARK LANE SCOTT CITY, KS 67871

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F 689	Continued From page 17	F 689		

the emergency room and treatment was applied to the skin tear. The results of the computed tomography (CT-medical imaging used to obtain detailed internal images of the body) scans of her head were all negative. The investigation documented staff were provided education not to leave a high-risk resident unattended.

The "Fall Investigation," dated 02/06/23 at 08:32 PM, documented R38 was found on the floor in her room, lying on her right side with her right arm and hand underneath her face. The investigation further documented the fall alarm was on the table in her room, not turned on, and a fall matt was to be placed beside the bed.

On 05/10/23 at 10:54 AM, observation revealed Certified Nurse Aide (CNA) M and CNA N sat R38 on the said of her bed,and did not put on a gait belt, per resident request. CNA M and N stood on each side of her, stood her up and slowly transferred her into her wheelchair.

On 05/10/23 at 11:00 AM, CNA M stated R38 had falls so there was a motion detector placed on the fall mat when she was in bed as well as a chair alarm.

On 05/15/23 at 08:20 AM, Administrative Nurse D stated staff should follow R38's care plan and educated staff to not leave her unattended.

The facility "Fall Prevention, Documentation, and Reporting" policy, dated January 2013, documented staff identify residents at risk for falls, initiate interventions to prevent falls, reducing the risk of injury due to falls. The staff shall assess all residents for fall risk upon admission and have fall precautions implemented

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175525	A. BUILDING _____ B. WING _____	05/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK LANE NURSING HOME	210 E PARK LANE SCOTT CITY, KS 67871

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 18 as appropriate, when a resident fall occurs after admission to the facility a root cause analysis shall be initiated ad an incident and accident report be completed. All trends are reported monthly to quality assurance/performance improvement committee. The facility failed to ensure a safe environment for R38. This placed the resident at risk for further falls and injury.	F 689		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any,	F 756		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175525	A. BUILDING _____ B. WING _____	05/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK LANE NURSING HOME	210 E PARK LANE SCOTT CITY, KS 67871

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 756	Continued From page 19	F 756		

action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.

§483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 46 residents. The sample included 12 residents with five reviewed for unnecessary medications. Based on observation, record review and interview, the facility failed to ensure the Pharmacist Consultant identified and reported the lack of an appropriate indication, or a documented physician rationale which included the multiple unsuccessful attempts for nonpharmacological symptom management and risk versus benefits for the continued use of an antipsychotic (class of medications used to treat mental disorder characterized by a gross impairment in reality testing) for Resident (R)39 and R38. This placed the residents at risk for unnecessary psychotropic (altering mood or thought) medication use and related consequences.

Findings included:

- The Electronic Medical Record (EMR) documented R39 had diagnoses of dementia, without behavioral disturbance (a disease that destroys memory and other mental functions).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175525	A. BUILDING _____ B. WING _____	05/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK LANE NURSING HOME	210 E PARK LANE SCOTT CITY, KS 67871

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 756	Continued From page 20	F 756		

The "Quarterly Minimum Data Set (MDS),"dated 03/17/23, documented the resident had a Brief Interview for Mental Status (BIMS) score of eight which indicated moderate impaired cognition. The MDS documented R39 received antipsychotic medication on a routine basis.

The "Care Area Assessment Summary (CAA)" for psychotropic drug use, dated 08/10/22, documented R39 received Zyprexa (antipsychotic medication) for dementia.

The "Black Box Warning" (strictest type of warning that the FDA (Food and Drug Administration) gives a medication, to bring major risks of taking the medication) care plan documented increased mortality for elderly patients with dementia treated with antipsychotic drugs are at an increased risk of death.

The "Physician's Orders," dated 10/13/22, directed the staff to administer Zyprexa 20 mg (milligrams) by mouth at bedtime for dementia without behavioral disturbance.

R39's clinical record lacked evidence of a documented physician rationale which included the multiple unsuccessful attempts for nonpharmacological symptom management and risk versus benefits for the continued use of an antipsychotic.

The monthly Registered Pharmacist Consultant reviews for 04/26/23, 03/22/23, 02/24/23, 01/26/23, 12/26/22, 11/25/22, and 10/27/22, lacked evidence the pharmacist identified and reported the inappropriate diagnoses for the use of the antipsychotic medication.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175525	A. BUILDING _____ B. WING _____	05/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK LANE NURSING HOME	210 E PARK LANE SCOTT CITY, KS 67871

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 756	Continued From page 21	F 756		

On 05/09/23 at 1:00 PM, observation revealed R39 sat on a chair in her room.

On 05/15/23 at 09:00AM, Administrative Nurse D verified R39 received an antipsychotic medication on a routine basis. Administrative Nurse D verified the Registered Pharmacist Consultant failed to alert the facility and physician of the inappropriate use of the antipsychotic medication.

The facility's "Antipsychotic Medication Use" policy, dated 07/2022, stated antipsychotic medications are used for a specific condition and will only be used based on the comprehensive assessment.

The undated "Pharmacy Consultant" policy stated monthly reviews of resident medications are to be done and the pharmacist is to provide recommendations for the facility and physician.

The facility failed to ensure the Registered Pharmacist Consultant failed identified and reported the lack of an appropriate indication for the use of an antipsychotic medication for R39 placing the resident at risk for adverse medication reactions.
- The Electronic Medical Record (EMR) for R38 documented diagnoses of hypertension (high blood pressure), anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), vitamin deficiency (a condition of a long-term lack of a vitamin), edema (swelling resulting from an excessive accumulation of fluid in the body tissues), intervertebral disc degeneration (breakdown of one or more of the discs that separate the bones of the spine causing pain in the back or neck), and weakness.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175525	A. BUILDING _____ B. WING _____	05/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK LANE NURSING HOME	210 E PARK LANE SCOTT CITY, KS 67871

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 756	Continued From page 22	F 756		

The "Quarterly Minimum Data Set" (MDS), dated 02/24/23, documented R38 had moderately impaired cognition and required extensive assistance of two staff for bed mobility, transfers, toileting, and extensive assistance of one staff for personal hygiene. The MDS further documented R38 received an antipsychotic (a class of medications used to manage delusions, hallucinations, and paranoia) medication seven days during the lookback period.

R38's "Black Box Warning Care Plan," dated 03/02/23, directed staff to monitor for adverse reactions, and Risperdal (an antipsychotic) medication increased mortality in elderly patients with dementia related psychosis and are at increased risk for death.

R38's "Abnormal Involuntary Movement Scale (AIMS) Assessment" (assessment for detection of involuntary movements related to use of an antipsychotic medication), dated 03/13/23, recorded a score of 0. (a score of two or higher indicates the resident has involuntary movements).

The "Physician Order," dated 11/03/22, directed staff to administer Risperdal, 0.5 milligrams (mg), by mouth, twice a day, for hallucinations related to anxiety disorder.

The monthly Registered Pharmacist Consultant reviews for 4/26/23, 03/22/23, 02/24/23, 01/26/23,12/26/22, 11/25/22, 10/27/22, 09/24/22, 08/24/22, and 07/20/22, lacked evidence the pharmacist identified and reported the inappropriate indication for the use of the antipsychotic medication.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175525	A. BUILDING _____ B. WING _____	05/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK LANE NURSING HOME	210 E PARK LANE SCOTT CITY, KS 67871

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 756	Continued From page 23 On 05/09/23 at 03:14 PM, observation revealed R38, in her wheelchair, by the television room. On 05/15/23 at 08:15 AM, Administrative Nurse D verified the inappropriate diagnosis for the medication and verified the pharmacist did not inform the facility. The undated "Pharmacy Consultant" policy stated monthly reviews of resident medications are to be done and the pharmacist is to provide recommendations for the facility and physician. The facility's failed to ensure the Consultant Pharmacist identified and reported to the Director of Nursing, R38's inappropriate diagnosis for the Risperdal medication. This placed the resident at risk for adverse side effects.	F 756		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs	F 758		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175525	A. BUILDING _____ B. WING _____	05/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK LANE NURSING HOME	210 E PARK LANE SCOTT CITY, KS 67871

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 24	F 758		

unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;

§483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;

§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and

§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.

§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 46 residents. The sample included 12 residents with five reviewed for unnecessary medications. Based on observation, record review and interview, the facility failed to provide an appropriate indication, or a documented physician rationale which included the multiple unsuccessful attempts for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175525	A. BUILDING _____ B. WING _____	05/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK LANE NURSING HOME	210 E PARK LANE SCOTT CITY, KS 67871

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 25	F 758		

nonpharmacological symptom management and risk versus benefits for the continued use of an antipsychotic (class of medications used to treat mental disorder characterized by a gross impairment in reality testing) for resident (R)39 and R38. This placed the residents at risk for unnecessary psychotropic (altering mood or thought) medication use and related consequences.

Findings included:

- The Electronic Medical Record (EMR) documented R39 had diagnoses of dementia, without behavioral disturbance (a disease that destroys memory and other mental functions).

The "Quarterly Minimum Data Set (MDS),"dated 03/17/23, documented the resident had a Brief Interview for Mental Status (BIMS) score of eight which indicated moderate impaired cognition. The MDS documented R39 received antipsychotic medication on a routine basis.

The "Care Area Assessment Summary (CAA)" for psychotropic drug use, dated 08/10/22, documented R39 received Zyprexa (antipsychotic medication) for dementia.

The "Black Box Warning" (strictest type of warning that the FDA (Food and Drug Administration) gives a medication, to bring major risks of taking the medication) care plan documented increased mortality for elderly patients with dementia treated with antipsychotic drugs are at an increased risk of death.

The "Physician's Orders," dated 10/13/22, directed the staff to administer Zyprexa 20 mg

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175525	A. BUILDING _____ B. WING _____	05/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK LANE NURSING HOME	210 E PARK LANE SCOTT CITY, KS 67871

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 26	F 758		

(milligrams) by mouth at bedtime for dementia without behavioral disturbance.

R39's clinical record lacked evidence of a documented physician rationale which included the multiple unsuccessful attempts for nonpharmacological symptom management and risk versus benefits for the continued use of an antipsychotic.

On 05/09/23 at 1:00 PM, observation revealed R39 seated on a chair in her room.

On 05/15/23 at 09:00AM, Administrative Nurse D verified R39 received an antipsychotic medication on a routine basis. Administrative Nurse D verified dementia was an inappropriate diagnosis for the use of the antipsychotic medication.

The facility's "Antipsychotic Medication Use" policy, dated 07/2022, stated antipsychotic medications are used for a specific condition and will only be used based on the comprehensive assessment.

The facility failed to have an appropriate indication for the use of an antipsychotic medication for R39 placing the resident at risk for adverse medication reactions.

- The Electronic Medical Record (EMR) for R38 documented diagnoses of hypertension (high blood pressure), anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), vitamin deficiency (a condition of a long-term lack of a vitamin), edema (swelling resulting from an excessive accumulation of fluid in the body tissues), intervertebral disc degeneration (breakdown of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175525	A. BUILDING _____ B. WING _____	05/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK LANE NURSING HOME	210 E PARK LANE SCOTT CITY, KS 67871

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 27	F 758		

one or more of the discs that separate the bones of the spine causing pain in the back or neck), and weakness.

The "Quarterly Minimum Data Set" (MDS), dated 02/24/23, documented R38 had moderately impaired cognition and required extensive assistance of two staff for bed mobility, transfers, toileting, and extensive assistance of one staff for personal hygiene. The MDS further documented R38 received an antipsychotic (a class of medications used to manage delusions, hallucinations, and paranoia) medication seven days during the lookback period.

R38's "Black Box Warning Care Plan," dated 03/02/23, directed staff to monitor for adverse reactions, and Risperdal (an antipsychotic) medication increased mortality in elderly patients with dementia related psychosis and are at increased risk for death.

R38's "Abnormal Involuntary Movement Scale (AIMS) Assessment" (assessment for detection of involuntary movements related to use of an antipsychotic medication), dated 03/13/23, recorded a score of 0. (a score of two or higher indicates the resident has involuntary movements).

The "Physician Order," dated 11/03/22, directed staff to administer Risperdal, 0.5 milligrams (mg), by mouth, twice a day, for hallucinations related to anxiety disorder.

The "Pharmacy Regimen Review," dated 04/26/23, recommended a risk versus benefit for the Risperdal medication but did not documented the inappropriate diagnosis.

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F 758	Continued From page 28 R38's clinical record lacked evidence of a documented physician rationale which included the multiple unsuccessful attempts for nonpharmacological symptom management for the continued use of an antipsychotic. On 05/09/23 at 03:14 PM, observation revealed R38, in her wheelchair, by the television room. On 05/15/23 at 08:15 AM, Administrative Nurse D verified the inappropriate diagnosis for the medication and verified the pharmacist did not inform the facility. The facility's "Antipsychotic Medication Use" policy, dated 07/2022, stated antipsychotic medications are used or a specific condition and will only be used based on the comprehensive assessment. The facility failed to have an appropriate indication for the use of an antipsychotic medication for R38, placing the resident at risk for adverse medication reaction.	F 758		